

## Clampdowns on out-of-network billing climb

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### Anne Paxton

**June 2016**—To the average reader, “out-of-network billing” might seem like a technical concept that should mainly concern hyperaware insurance wonks. Media outlets from NBC News to *Time* to the Huffington Post have found that phrases like “surprise medical bill,” “angry patients,” and sometimes “sticker shock” in recent stories are much more likely to grab attention.

But out-of-network billing is what those stories are about—and it’s not being painted in glowing terms.

In fact, a growing number of states have imposed curbs on out-of-network billing, and the implications for pathologists could be serious. However, pathologist awareness of the trend is lagging, says Margaret Havens Neal, MD, president of the Florida Society of Pathologists. “There are pathologists out there who don’t recognize this as a major issue for them yet.”

“Anecdotally, we hear about surprise medical bills more and more,” says Emily E. Volk, MD, MBA, chair of the CAP Council on Government and Professional Affairs and chief quality officer, Baptist Health System, San Antonio. And pathologists, along with other hospital-based physicians such as radiologists, anesthesiologists, emergency physicians, hospitalists, and neonatologists, are among the billers being highlighted.

Almost one in every three privately insured adult patients had received a surprise medical bill in the previous two years, a 2015 *Consumer Reports* survey found. When such patients find out they owe unexpected amounts because the provider who took care of them is not part of the network covered by their insurance—even though the facility may be covered—it’s the provider who often gets the blame.

Why are such out-of-network bills on the increase?

“It’s because insurance companies are creating narrow networks, limiting the number of physicians patients see, so more and more physicians become ‘out of network,’” says Robert DeCresce, MD, MBA, director of clinical laboratories at Rush University Medical Center in Chicago and chair of the state affairs subcommittee of the CAP



“We don’t particularly want or choose to be out of network, but as the insurers’ networks have narrowed, we find ourselves out,” says Dr. A. Joe Saad.

“Even if you go to an in-network hospital, the hospital may not give you a choice between an in- or out-of-network pathologist because their contracts are usually exclusive.” Then the patient gets billed for the difference between what the insurance company allows and what the pathologist charges. “Is it a deceptive practice by the hospital or the insurance company? That’s a reasonable question to ask,” Dr. DeCresce says.

Some of the rise in such cases may be linked to the Affordable Care Act, Dr. Volk says. “There are ACA provisions for controlling costs of patients seeing in-network providers, but the same provisions are not extended to care received from out-of-network providers, even though the patient has no real choice in determining what providers are in or out of network. Patients often have no idea whether or not their provider network is broad enough to begin with. Often patients don’t know they don’t have adequate coverage until after they’ve received treatment and are discharged.”

Whatever the cause, states are exploring various proposed solutions to the problem, says Dr. DeCresce. “One solution is to ban balance billing, and some states have done that.”

**Confusion can arise over use of the term “balance billing”** to describe out-of-network billing. The older and more traditional definition of balance billing, explains attorney Jane Pine Wood of McDonald Hopkins LLC, Dennis, Mass., is the billing of a patient by an out-of-network health care provider for the difference between the provider’s list charge and the amount that the patient’s payer approved as the maximum allowable charge—not including deductibles, coinsurance, or copayments for which the patient is responsible.

More recently, balance billing has been used at times to refer to *any* difference between what the provider charges and what the patient pays, including deductibles, coinsurance, or copayments.

As Wood points out, traditional balance billing can be, and sometimes is, banned by states as a response to surprise medical bills, but pathology and laboratory providers risk violation of fraud and abuse statutes if they either waive or reduce the amount owed by the patient for an applicable copayment, deductible, or coinsurance. “Under federal law and under most state laws, the routine waiver or reduction of the amount the patient owes for the out-of-network copayment, deductible, or coinsurance amounts can be considered as a violation of false claims laws.”

A significant concern facing pathologists and laboratories in this context is “how to lower the patient out-of-network balance while not engaging in a routine waiver of copayment, deductible, or coinsurance amounts that could lead to allegations of false claims,” Wood says.

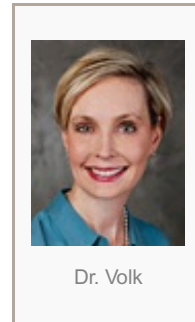
A ban on balance billing would appear to be the most simplistic approach, but it leaves unanswered who will pay the balance, Dr. DeCresce says. “Depending on what state you’re in, there could be an arbitration or negotiation between the doctor and the insurance company to determine what would be a fair payment for the out-of-network doctor. You could have an arbitrary fee schedule set up for balance billing, as New York state does. Or you could say the doctor has to take what the insurance company pays him—tough luck.”

New York physicians also have to provide patients with a written estimate of what the charge is going to be. But, Dr. DeCresce notes, “With pathology, it’s hard to determine what the charge will be, because it varies a lot by what happens and the physician can’t predict that. New York also says with non-emergent surgery or care, if the patient goes to a place with out-of-network doctors, there’s a responsibility to give the patient an estimate so they can decide whether to go to that hospital or not. But that’s a lot of onus to put on the patient.”

Having the patient ask questions about whether a provider is in network is also unlikely to be an effective intervention, Dr. Volk points out. “I think that’s asking quite a bit of a patient beneficiary, frankly. Certainly at the time of emergency care, who’s going to remember to ask every possible provider ranging from emergency physician, anesthesiologist, pathologist, radiologist, and surgeon: ‘Are you in my network?’”



Insurance carriers have gotten a bit of a free ride on this issue, she says. “They’re saying how terrible it is for patients to receive high out-of-network bills and there should be limits. But the real answer for patients is to have an adequate network. When you have surgery, you don’t just need the surgeon or the facility in your network. You need everyone who’s going to potentially touch the patient.” In her view, the proliferation of less expensive insurance plans to meet the needs of the ACA has possibly driven the emergence of narrower networks.



The CAP, which keeps members posted on state legislation via its weekly “Statline,” is advocating for state measures that address the problem of network adequacy rather than the symptom of out-of-network billing. “We’re working very hard to frame this appropriately as a patient access to care issue and patient coverage adequacy issue rather than a ‘selfish doctors wanting to be paid’ issue,” Dr. Volk says.

“When patients are purchasing insurance plans with networks so narrow that not all providers they need are covered, they don’t get the benefit of what they thought they bought.” Both anatomic and clinical pathology are affected, Dr. Volk adds. “When a network covers a patient’s lab services only through a commercial lab, the pathologist’s work doing medical oversight at the hospital lab has to be billed to the patient. But that’s work that, arguably, should be appropriately reimbursed as part of patients’ coverage.”

For physicians trying to respond to patient concerns, options can be limited. Most insurers prohibit physicians from waiving out-of-network charges in an effort to “punish” the patient for choosing a non-network provider. Says Dr. DeCresce, “That may be okay when patients affirmatively choose an out-of-network physician—but not so fair when the patient had no choice.”

**Medicare subscribers are not affected by the** out-of-network billing issue because physicians accepting Medicare are automatically considered to be in network. However, says A. Joe Saad, MD, chair of the CAP Federal and State Affairs Committee, Medicare Advantage plans, administered by companies like United Healthcare or Aetna rather than by the Centers for Medicare and Medicaid Services, do have networks that are restricted, and new federal legislation passed in 2015 will be pushing more Medicare patients into those plans. So he thinks network problems will compound.

What the health plans are doing, “mostly to keep their profits up but they say it’s to keep their costs down, is narrowing their networks, tailoring them geographically and excluding hospitals and physicians in many areas of a city,” says Dr. Saad, who is chair of pathology at Methodist Health System in Dallas.

The CAP position on out-of-network billing, developed in 2013, is that if the health plan does not provide the patient with an in-network provider option, the patient should be paying the in-network rate and the health plan should be responsible under law for the balance billed amount.

Informally, Dr. Saad says, a network that includes 70 percent or more physicians in a community is considered a broad network, between 70 percent and 30 percent is considered narrow, and less than 30 percent is considered ultra-narrow. “A lot of these narrow networks just came into existence with the passage of the ACA in 2010 and the changing insurance environment as a result of that. In the past three years, the problem has gotten much worse.”

An additional wrinkle is tiered networks. “You may find yourself, as a hospital-based physician, to be in network for someone who has a Gold plan but out of network for someone with a Bronze plan. They have so many different products, it’s very difficult for us to figure out if we’re in or out of network. And quite honestly, it’s hard for insurance companies to figure it out. I can’t imagine how a patient could do it.”

Separate deductibles for out-of-network providers are another way insurance companies can avoid payment. “In network your deductible may be \$5,000, while out of network it might be \$10,000,” Dr. Saad says by way of example. “So they’re not saying, ‘We’re not covering pathology.’ They’re saying, ‘This is an out-of-network service

and it's covered at our out-of-network rates.”

“The bottom line is they're trying to make consumers more accountable and to think of health care as a service that needs to be shopped for, just as you'd shop for a car. And most people would shop around. But this is a difficult market. It's not as transparent as it needs to be with the physician directories, coverage of services, and how a patient can actually access the most cost-effective care. So this is shifting the burden of shopping onto patients who are ill-educated in this field, not through any fault of their own.”

State insurance regulators, represented by the National Association of Insurance Commissioners (NAIC), have abrogated their responsibility, in Dr. Saad's view. NAIC convened a group to look at network adequacy, which the CAP believes should be a priority. “But even though they're well intentioned, they figure it's a lot easier to regulate physician billing than it is to regulate health plan network adequacy.” In Texas, for example, insurance regulators have testified before the legislature that they're actually certifying networks they know are inadequate, he says. “They may not have the manpower, or they may be convinced this is what they need to do to keep costs down.”

The CAP had many conversations with the NAIC, Dr. DeCresce says, “to get them to want people to enforce network adequacy. And the NAIC's response was, well, any network that is approved must be adequate, and it's not necessarily their responsibility to enforce it.” Similarly, “We wanted the NAIC to agree that patients should be held harmless when networks are inadequate, and they rejected that too.” So the NAIC wouldn't put it in its model bill (although in some states, such as Illinois, that provision is in state law). However, the NAIC did agree it was impossible for certain specialties to provide a written estimate, he says. “They understood, and that requirement was deleted from the model bill, even though New York state requires it.”

Dr. Saad objects to the NAIC's unwillingness to recognize hospital-based physicians as a separate class of physicians. “We are a little bit different from other physicians. We're not like a primary care doctor or even a specialist where they look at, within a network, the time and distance it would take a patient to travel to see a specialist. Once you're admitted to a hospital for a procedure, then time and distance don't apply; that pathologist is either in network or not in network. So they need to establish different criteria for us, but we couldn't get the NAIC to recognize that.”

Some states are starting to see that the fundamental problem is inadequate networks, and even in Texas there has been an intermediate step, Dr. Saad says. “If a patient gets a bill from an out-of-network hospital-based provider—and it used to be if the bill were over \$1,000; now it's if the bill is over \$500—the patient can request mediation.” He wishes other states would adopt Texas' step before that mediation, which is a three-way conference call among the patient, provider, and insurer. “Around 90 percent of the time, they agree on a solution to who is going to pay what. The other 10 percent of the time it goes to mediation.” (The Texas Department of Insurance's website has a section on surprise medical bills and explains how patients can handle them, at <http://bit.ly/tdi-surprisebill>.)

In other states, such as New York, out-of-network balance billing (after the patient has covered deductibles and copayments) is banned. “If you send a bill out of network, then the insurer has to cover it at the 80th percentile of a database of billions of charges called the Fair Health Database,” Dr. Saad explains. That's not a perfect solution for pathologists, though, because New York law also requires hospital-based physicians to give upfront estimates of what the charges will be. “For pathologists, that's problematic because we never know ahead of time what the charges will be. We don't control the specimens, and we have no way of knowing how many specimens the surgeon is going to send to us,” Dr. Saad says.

In addition, “If it's a breast biopsy and it's benign, that's one thing, but if it ends up being cancer, we need to do a whole lot of other tests on it.” Getting consent from a patient before the test is a problem too, “because as pathologists we never see the patient. We never know up front who is coming in to have surgery, so Medicare, self-pay, Medicaid, Blue Cross—anyone who comes through the door—we treat the same.”

Patients themselves have rarely been the source of complaints, in his experience. “Texas has a law that if a patient

requests an estimate of charges we're required to provide it, but I've never had a patient request that. I've gotten a handful of complaints for an out-of-network bill but most of the time we've worked with the patient and reached a satisfactory accommodation on an appropriate charge."

Receiving a surprise bill is the patient's main problem. "They don't anticipate getting an out-of-network bill from a pathologist because a lot of patients don't even know what a pathologist is; they would expect the service to be part of the hospital charge. When they register at the hospital, they're given a stack of papers and in that stack they sign something about us, but there are 20 or 30 different forms. So even though there's disclosure, it's kind of last-minute disclosure."

While the ACA has exacerbated the narrow network problem, he says, it's not due entirely to the ACA, "because, for example, in Texas we've been dealing with this narrowing for 10 years."

The CMS does have some regulatory oversight, Dr. Saad says, because of the federal exchange programs set up by the ACA. "They have recognized the problem, but basically deferred any kind of regulatory activity to the individual states to deal with through the NAIC and through state legislation."

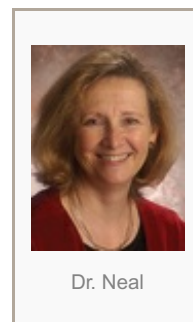
The same applies to network adequacy; they have thrown that issue back to the states, he says. "The CAP proposed to the Department of Health and Human Services that there be a federal network adequacy rule," Dr. DeCresce says. "But the federal government elected not to make that part of the federal health exchange."

To date, hospitals also have stayed neutral on out-of-network billing, Dr. DeCresce notes. "The American Hospital Association has no position as of yet. But as networks get narrower and narrower, hospitals will start being excluded, and they may change their tune too."

In his own practice, Dr. Saad has been trying to negotiate a contract to be in the Cigna network for 18 years. "We get a response that 'our networks are closed to independent labs.' It's painful for the insurance plans to not have an adequate network. And it's painful for the physicians and pathologists to be out of network. The question is, when do you reach that pain level where the parties will just sit down and negotiate a rate that all parties can live with?"

In an ideal world, Dr. Saad believes, there would be bilateral negotiations between pathologists and insurance plans to reach in-network payment that's fair. "All we're trying to do is get paid fairly for our services," he says. "We recognize the complexity of this issue and that a lot of it has to do with inadequate networks, so we're looking at ways to come up with a patient-centric solution. We don't want the patient stuck in the middle as a result of the terrible insurance products that are being sold."

**Out-of-network billing has been top and center** of Florida pathologists' advocacy agenda for several years, says state pathology society president Dr. Margaret Havens Neal of Ketchum, Wood & Burgert Pathology Associates in Tallahassee. Until recently, the state society's efforts have succeeded in fighting legislation against balance billing. (Similar campaigns this year in Tennessee and Colorado held off balance billing proposals as well.)



Dr. Neal

But with years of growing pressure and advancement of Florida's legislative leadership, balance billing ban proposals moved to the front of the legislative agenda. "Maybe because of the whole health care environment, balance billing was a primary issue this session. So pathology believed we needed to compromise, recognizing that balance billing legislation was all but certain." A bill was passed unanimously and signed, to take effect July 1, relating to out-of-network health insurance coverage and applying to all emergency and nonemergency noncontracted, covered services provided in a participating hospital setting.

The measure could have been worse. In the past, bills that were filed always had reimbursement based on a maximum percentage of Medicare, and the current bill does not contain that provision.

Unfortunately, pathologists still need to get up to speed on the issues, Dr. Neal says. "It will take a few months for

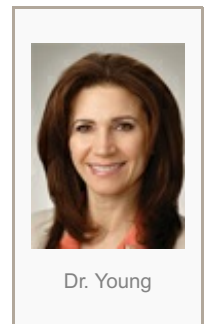
folks to recognize what's really happening to them. For covered services provided under an individual or group health insurance policy delivered or issued for delivery in this state, a nonparticipating hospital-based pathology group will only be able to seek reimbursement from the insurer. Health insurers will be exclusively and solely responsible for reimbursing the pathology group, reduced, though, by the patient-insured cost-share responsibilities." She suspects some pathology groups will seek legal counsel to obtain payment from insurers. "We expect to hear a lot of discussion and discord and probable legal action in the second half of this year and next year," she says.

Despite the Florida society's communication efforts, "People don't really recognize this kind of thing until they start seeing their bottom lines change." The professional component of pathology clinical laboratory (PC/TC) services is one of the main service components at risk of not being paid, she says. "We've had lawsuits in the past with pathologists throughout the state gathering to help, so I suspect we'd do it again if it goes down that road."

In New Hampshire, there has been a struggle to gain visibility for pathologists' concerns, says Eric Loo, MD, who represents the New Hampshire Society of Pathologists for the state medical society. "The state insurance department is attempting to revise the list of minimum services required for an insurance provider to be network adequate. But both the prior version and the recently proposed changes completely excluded pathology physician services from their assessment metrics. They include metrics for the surgical service to obtain a biopsy, but nothing for processing and assessment of the biopsy post-procurement." Other hospital-based physician services such as radiology and anesthesiology have not been represented either, adds Dr. Loo, assistant professor of pathology, Dartmouth Geisel School of Medicine.

The proposals have been developed behind the scenes as well. "If it weren't for the CAP's 'Statline' updates, we wouldn't know what's been going on," Dr. Loo says. "Fortunately, when the insurance department put forward the deficient list of rule sets for minimum network adequacy, with assistance from the CAP we were able successfully to block it at the statehouse. CAP and our state pathology society are still advocating for pathology to be included in the adequacy metrics. The network adequacy proposal was additionally linked to a proposed ban on balance billing and would have hurt pathologists statewide," says Dr. Loo.

Among Pennsylvania pathologists, too, awareness of the issues surrounding out-of-network billing is not very high, says Nancy A. Young, MD, immediate past president of the Pennsylvania Association of Pathologists and chair of pathology and laboratory medicine for the Einstein Healthcare Network. The state insurance department testified about a draft bill before the state legislature in March, which would require pathologists and other out-of-network providers to settle for whatever the health plan would want to pay them, and not necessarily be able to collect the balance. If there were no agreement, then an arbitrated resolution would be sought. Dr. Young only recently found out about the bill by reading the "Statline" alerts, she says. "I think a lot of these things happen and pathologists are so busy doing day-to-day work" they might miss it.



Such balance billing bans can sound like a great measure for patients. But, Dr. Young notes, "They would discourage health plans from maintaining physician network adequacy. And the more they exclude, the more likely patients are going to encounter these out-of-network billing situations." To her, it's odd that the insurance department would be seeking this law when there have been only about 35 patient complaints about balance billing since 2014. "It seems that the insurance department may be favoring the insurance companies, since a ban would be a strong incentive for health plans to reduce their provider networks."

She works in a hospital that has a disproportionate share of charity work and finds that more patients have insurance than before, due to the ACA, but many are underinsured and are facing rate increases, making their insurance less and less affordable. "I'm a patient too, and I wouldn't want to be stuck with a huge bill, so I understand that. But I also think we can't rig the system so insurance companies can provide very narrow networks."

“Even for those of us in academic settings or employed by hospitals, these types of issues can eventually undercut the practice of pathology and make things difficult for us.”

The CAP’s educational work on out-of-network billing has been invaluable, Dr. Young says. “Most state societies do not have the infrastructure to do this kind of education of legislators and the insurance commissioner.”

**Over the nearly three decades that Jane Pine Wood** has been practicing law in this area, out-of network billing was never a big issue until the past four or five years, she says. “Most attorneys would generally advise clients to try to bill at least an in-network balance, if not the out-of-network difference. But no one worried too much about it.”

Formerly, fewer laboratories were out of network, she adds. “In today’s world, it can be very hard for most labs or pathology practices for outreach work to get in network with major payers,” many of whom will contract only with one of the few large national labs. Where those contracts are exclusive or mostly exclusive, they can get very advantageous pricing, she notes.

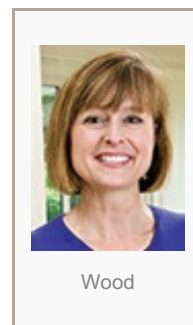
And antitrust challenges against that practice, to date, haven’t been successful, she points out, because under the U.S. Constitution, the freedom to contract among private parties is protected by the Commerce Clause. “We can’t tell someone whom to contract with, as long as they’re not discriminating, so the payers have decided they would rather contract with large labs. The payers argue they have fewer entities to credential and can work out a lot of data points and gather a lot of information and streamline the cost significantly.”

“Generally payers have the ability to have whoever they want in or out of contract as long as they offer a broad enough array of services. They just have to make sure there is service availability for their subscribers.”

At the same time, there has been a significant increase in the dollar amount of some testing. “I don’t see a lot of out-of-network issues coming up with anatomic pathology billing,” Wood says. “I see it come up with high-end molecular testing, such as prenatal testing, and toxicology testing, because such testing often is ordered in large panels where the aggregate bill for data services is also very large.”

When payers are paying such significant dollar amounts, it becomes even more important for them to have that patient cost-sharing. “So that patient is also acting as a gatekeeper for the test ordering and is more likely to ask questions to drill down to whether this is a test they really need.”

Reinforcing that market dynamic, some of her clients have reported receiving letters from carriers noting that their laboratory is not collecting the full balance from patients, and refusing to pay, in the future, without seeing evidence that the provider has collected all balances. “Cigna has done that to a number of laboratories, surgery centers, and other providers.”



The reason is that under federal and most state laws, submission of a claim to a third-party payer where the laboratory or pathology practice has decided in advance that it’s not going to collect the full balance from the patient can be deemed a false claim, Wood says. Contractually, she explains, in an out-of-network situation, the payers’ only obligation is to the patient/subscriber, to pay a portion of what the subscriber owes. So if a provider agrees to reduce the amount billed to the patient, it would be a false claim to bill the payer based on the original unreduced amount.

For example, in New York state, blanket waivers or blanket reductions of patient balances are in violation of the state’s general fraud and abuse statute, Wood says, and some of her clients say they’ve received letters from the state noting that blanket waivers or reductions can lead to revocation of their laboratory license. (New York’s law expressly allows a waiver of these charges based on a patient’s “inability to pay.”) In Florida, a specific state law provides potential felony penalties for a health care provider who fails to bill a patient balance to the patient.

Historically, insurance companies lobbied for these laws, she says. “The companies want the patients to be responsible for the balance so the patients have a vested interest in whether they want to get the testing done, or

any other health care service, since these are not laboratory-specific laws.”

Many of her clients simply want to be in network with payers. “It’s exclusion from the network that is so difficult,” she says. Some clients are also rethinking their pricing. “Those who have very expensive testing are actually considering a lower price so both the payers and the patients would pay less, because they are looking at how to get the patient balance down and be compliant. A lot of this molecular testing is not covered, so then the issue is whether they can get more volume through self-pay work.”

Network adequacy, Wood points out, is a lot easier to advocate in anatomic pathology. “If you’re talking about a CBC or a prenatal test, there’s a whole lot of testing that can go anywhere in the country via FedEx, so adequacy of network tends to fall apart. If the payer has LabCorp in the network, it’s hard to say there is something LabCorp cannot make available.”

The New York and Florida laws that ban balance billing by hospital-based providers attempt to address remedies for patients. “But they are very odd and very cumbersome laws, and we’ve really yet to see how they are going to play out in actual practice.” If “any willing provider” legislation could get passed—obliging health insurance carriers to accept all providers—that would be ideal, Wood says. “But that tends to be on a state-by-state basis,” and it too may not survive freedom of contract scrutiny. “Some of the ‘any willing provider’ legislation has been struck down based on violation of freedom of contract.”

**There are three major priorities for the pathology** profession in handling out-of-network billing, Dr. Saad says. The first is network adequacy. “We don’t particularly want or choose to be out of network, but as the insurers’ networks have narrowed, we find ourselves out. Insurance regulators need to do their job and not certify plans that have insufficient numbers of hospital-based physicians.”

Second, “Companies need to notify enrollees of the limits of their insurance coverage, provide them with reasonable access to in-network physicians at in-network facilities and hospitals, and inform patients how to best use the insurance product to get maximum coverage and benefits.”

Finally, insurance plans, when the network is inadequate, need to hold patients harmless. To ensure that these reforms come to pass, CAP members need to keep up to date with these issues and track what is happening in their states.

Pathologists who don’t do out-of-network billing may read about it and wonder how it matters to them. But there are two reasons why it should matter, Dr. DeCresce says. One, it is a terrible public relations problem for pathologists. In many cases, “a lot of this bad PR is unfortunately driven by doctors who take advantage of the situation and are dishonest and crooks. We’re not trying to protect that or advocate for that in any way.”

“And second, there’s the endgame,” he adds. “Once balance billing is banned, and once out-of-network billing is banned, then the insurance company will have little or no interest in negotiating fairly with doctors on how much they’re going to be paid. We’re not so concerned about anesthesiologists or pathologists writing ridiculous bills. They should not be able to do that. But we’re concerned about the honest, legitimate person, who is not even involved in this, suddenly discovering that the insurance companies have no interest in negotiating with them. So we want to get those doctors to understand why out-of-network billing and bans on balance billing are such an important issue.”

*Anne Paxton is a writer and attorney in Seattle.*